STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Adult Day Services Program

Application

SECTION 1: Program Information			
Program Name:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR ADULT DAY SERVICES PROGRAM	
Please include two (2) separate checks/money orders for each subsection. A. Number of Adults/Consumers to be served at this program (Select one): ☐ Up to 10 consumers (fee $10) ☐ 11 – 20 consumers (fee $20) ☐ 21 – 30 consumers (fee $30) ☐ 31 – 40 consumers (fee $40) ☐ 41 or more consumers (fee $50) **Total Fee Enclosed for licensed capacity ……..**	$ _____
B. Background Checks (Select all that apply): ☐ Applicant (fee $31) ☐ Administrator (fee $31) **Total Fee Enclosed for background checks ……..**	$ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Checks/Money Orders enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Adult Day Services Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: dlrs.info@maine.gov

Office Use Only:
Check# _____ MO # _____ Amount $_____ Initials: _____ License# _____
SBI _____ Water _____ HFS _____ Ins. _____ SFMO _____ Multi-Level _____
County _____ Prog. Spec _____

SECTION 3: Program Administrator Information (to be completed by the Administrator)
A Résumé may be submitted in lieu of completing the sections on education, experience and employment.

Legal Name:			
Familiar Names (i.e. maiden name, aliases):			
Home Address:			
City:	State:	Zip:	County:
Date of Birth:	Social Security Number:		
Telephone No.: ( )	Fax No.: ( )		
Email Address:			

Education:

School Name	City/State	Last Grade Completed	Degree	Year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Special Qualifications: Enclose a copy of all pertinent credentials.

Please check all that apply:

- ☐ Multi-Level Administrator's License
- ☐ Registered Professional Nurse
- ☐ Certified Nurse's Aide
- ☐ Sign Language
- ☐ Other Spoken Language: _____
- ☐ CPR
- ☐ Residential Care Administrator's License
- ☐ Licensed Practical Nurse
- ☐ Certified Residential Medication Aide
- ☐ Residential Care Specialist I certified
- ☐ Direct Support Specialist
- ☐ Personal Support Specialist
- ☐ Other, explain: _____

Employment History: Provide the last five (5) years of employment history (attach separate sheet if necessary).

Name and Address of Employer	Job Responsibilities	Dates From	Dates To	Reason(s) for Leaving
_____	_____	_____		_____
_____	_____	_____		_____
_____	_____	_____		_____
_____	_____	_____		_____
_____	_____	_____		_____

Other Relevant Experience:

Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use back of page, if necessary). _____

_____

Safety and Security:

The following questions are used to help evaluate the safety and security of consumers who will be served in the program. Issues in the following areas do not automatically mean a license will be denied.

Have you ever been convicted of a criminal offense?

- ☐ No
- ☐ Yes, please explain: _____

  _____

  _____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- ☐ No
- ☐ Yes, please explain: _____

  _____

  _____

Have you been investigated for child or adult abuse, neglect and/or exploitation?

- ☐ No
- ☐ Yes, please explain: _____

  _____

  _____

Have you ever been treated for drug/alcohol abuse?

- ☐ No
- ☐ Yes, please explain: _____

  _____

  _____

Have you ever been an inpatient in a mental health facility?

- ☐ No
- ☐ Yes, please explain: _____

  _____

  _____

Professional References: Submit attached completed references with application.

Name	Address	Daytime Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: Applicant Information (if different from Administrator)			
Legal Name:			
Familiar Names (i.e. maiden name, aliases):			
Home Address:			
City:	State:	Zip:	County:
Date of Birth:	ID# (Owner SSN or EIN#):		
Telephone No.: ( )	Fax No.: ( )		
Email Address:			

Ownership by a Corporation:

Please select all that apply:

- ☐ Corporation
- ☐ Individual
- ☐ Partnership
- ☐ For Profit
- ☐ Non Profit

If owner is a corporation, list on a separate sheet the names, addresses, and titles of each officer, director, and each person owning 10% or more of the total stock, specifying the percentage of ownership.

Have you ever been convicted of a criminal offense?

- ☐ No
- ☐ Yes, please explain: _____

_____

_____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- ☐ No
- ☐ Yes, please explain: _____

_____

_____

Owned and/or operated by applicant or spouse:

List ALL Home Health Agencies, Registered Personal Care Agencies, Adult Day Services and Long Term Care Facilities (including assisted housing and nursing facilities) owned and/or operated by applicant or spouse.

Name	Address	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 5: Facility/Program Information

Facility Description: (Check all that apply)

1. Type of dwelling:
   - ☐ House
   - ☐ Duplex
   - ☐ Apartment
   - ☐ Mobile Home
   - ☐ Commercial Building

2. Approximate age of home: _____

3. Landlord's Name (if applicable): _____
   _____

4. Number of exits from building, including fire escapes:
   _____

5. Are rooms currently furnished with required furniture?
   - ☐ Yes
   - ☐ No, list expected date of completion: _____

6. Will a listed telephone be available for use by clients?
   - ☐ Yes
   - ☐ No

7. Sewage system:
   - ☐ Municipal
   - ☐ Other: _____

8. Water Supply:
   - ☐ Municipal
   - ☐ Other: _____

9. Number of rooms and bathrooms available for consumer use:

	Rooms / Square Feet	Bathrooms
1st Floor	_____ _____	_____
2nd Floor	_____ _____	_____
Basement	_____ _____	_____

10. Type of heating: _____

11. Are all windows screened:
   - ☐ Yes
   - ☐ No

12. Physical features of the home:
   - ☐ Wheelchair ramp
   - ☐ Handicap accessible
   - ☐ Smoke detectors and extinguishers
   - ☐ Intercom system
   - ☐ Elevator

Program Information:

Type: (Check all that apply)
- ☐ Social Adult Day Services Program
- ☐ Adult Day Health Services Program
- ☐ Day Services Only
- ☐ Night and Day Services
- ☐ Night Program Only

Days/Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
_____	_____	_____	_____	_____	_____	_____

Staff (minimum ratio one (1) staff / six (6) consumers:

Administrator Name: _____	Age 21 or over?	☐ Yes	☐ No
Other Staff Name(s): _____	Age 18 or over?	☐ Yes	☐ No
_____	Age 18 or over?	☐ Yes	☐ No
_____	Age 18 or over?	☐ Yes	☐ No
_____	Age 18 or over?	☐ Yes	☐ No
_____	Age 18 or over?	☐ Yes	☐ No
_____	Age 18 or over?	☐ Yes	☐ No

Type of population to be served: (Check all that apply)

Age Range: _____
- ☐ Male
- ☐ Female
- ☐ Dementia/Alzheimer's disease
- ☐ Persons with mental illness
- ☐ Persons with mental retardation or developmental disabilities
- ☐ Persons with acquired brain injury

SECTION 6: Submission

Submit your completed application, the following additional information and two copies of your application and additional information:

- Two (2) checks or money orders made payable to "Treasurer, State of Maine"
- Admissions Policy on participants who are appropriate
- Names/Addresses of Board of Director, if applicable
- Floor plan of facility identifying program area(s), and exits, including dimensions of rooms
- A copy of the lease agreement, if applicable
- Three (3) written references for the applicant and administrator from persons who are not related by blood or marriage (Please see attached questionnaire for completion by references)
- A copy of all pertinent credentials for the Administrator

The following information must also be submitted. These may be submitted with the completed application or at the time of the scheduled onsite visit:

- Certificate of Insurance for property, liability and vehicle (if transportation is provided by the program). Not required for a licensed nursing facility.
- Evidence of compliance with Federal, State and municipal laws, codes, and ordinances which regulate health, fire safety, building, land use, and sanitation. Not required for a licensed nursing facility.
- Written Emergency Plan
- Medication Administration Policy
- Written Refund Policy
- Written Complaint Resolution Policy
- Confidentiality Policy
- Samples of the consumer records forms for the proposed program as outlined in the regulations

Failure to submit the required information will delay the processing of your application.

SECTION 7: Declaration

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

- I/We are applying for a license to operate an Adult Day Services Program for _____ adults, in accordance with Title 22, MRSA §8601 et. seq. and the Department's licensing regulations.
- I/We certify that all information provided herein is true and correct to the best of my knowledge.
- I/We certify that I am in compliance with all local laws and ordinances as they relate to zoning, plumbing, water supply, and sewage disposal.
- I/We, being duly authorized to assume responsibility for the adult Day Services Program herein described, do hereby apply for a license to operate the program and do agree to assume responsibility that the program will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA §7801.
- I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain criminal history and Bureau of Motor Vehicle records, which may be on file in any county or state office.

_____	_____	_____
Print name of Applicant	**Signature of Applicant**	**Date**
_____	_____	_____
Print name of Administrator	**Signature of Administrator**	**Date**

Reference Form for Adult Day Services Program Providers

Name of Proposed Administrator/Applicant: _____
Name of Facility: _____

Please respond to the following questions (use the back of this sheet, if necessary):

1. How long have you known the applicant/administrator: _____
2. In what capacity do you know this applicant/administrator: _____
   _____
3. Are you familiar with this person's experiences in serving people who are elderly or disabled?
   - ☐ No
   - ☐ Yes, Please describe: _____
     _____
4. Describe this person's ability to give care and services to people who are elderly or disabled: _____
   _____
   _____
5. Describe this applicant's/administrator's strengths and weaknesses in the following areas:
   a) Coping with problems and stress: _____
      _____
      _____
   b) Working with other people: _____
      _____
      _____
   c) Decision-making: _____
      _____
      _____
   d) Communication and listening skills: _____
      _____
      _____
   e) Ability to work with outside resources, such as social workers, medical professionals, state agencies, friends and families of resident, etc. : _____
      _____
      _____
2. Do you have any concerns about this person's ability to work in or operate an Adult Day Services Program?
   - ☐ No
   - ☐ Yes, please explain: _____
2. Do you recommend that this person be given the opportunity to work in or operate an Adult Day Services Program?
   - ☐ Yes
   - ☐ No, please explain: _____
3. Additional Comments: _____
   _____
   _____

Reference Information

Name of person completing this form: _____ Telephone: _____
Home Address: _____
Occupation: _____

_____ _____

Signature of Reference **Date**